New Services Subcommittee Meeting

Meeting Minutes: 11/04/2015
10 a.m. to noon (Central time)

Attendees: Kim Malsam-Rysdon, Jerilyn Church, Sonia Weston, John Mengenhausen, Deb Fisher Clemens, Monica Huber, Brenda Tidball-Zeltinger, Lynne Valenti, Edmund (Eddie) Johnson Jr, Bernie Long, Evelyn Espinoza, Capt. John Schuchardt

Welcome and Introductions

The group introduced themselves and Kim Malsam-Rysdon welcomed everyone.

Review Purpose of New Services Subcommittee

Kim Malsam-Rysdon reminded the group about the purpose of this subcommittee and its role in support of the larger Health Care Solutions Coalition. The focus of the New Services Subcommittee will be to learn more about Community Health Representatives (CHRs) and Medication Therapy Management (MTM) – services and determine if these services could be leveraged to increase access to services through Indian Health Services and Tribal programs and reduce other costs to the Medicaid program.

Community Health Representatives

Based on the organizing call with the group last week, three people were asked to present information about the CHR programs in their areas: Bernie Long, Evelyn Espinosa, and Sonia Weston.

Bernie Long, IHS Ft. Thompson – This is the only program in the Great Plains Area with the federal CHR program under IHS. The program transitioned from the tribe, and they have been working to expand the CHR services. The population in this area relies very heavily on CHRs for transportation. The CHRs also work closely with the public health nursing (PHN) staff and coordinate for a number of patients. Ft. Thompson also is a Medicaid Health Home provider, and the CHRs help support that program. The clinical staff meets as a team on a list of patients and their conditions to talk about the best way to reach them and meet their needs. The CHRs help a lot with this work and do a lot of home-based visits and services, such as working with prenatal patients. They know where people in the community live. Big Bend, Ft. Thompson and Crow Creek are all part of this service area, and there are CHRs that represent each community. The Ft. Thompson IHS would like for the CHRs to be able to deliver medications to patients. Lack of transportation results in quite a few prescriptions that don't get picked up, and the CHRs could help deliver them, and perhaps even do some follow up to make sure they take them.

It is very difficult to find CHRs – Ft. Thompson IHS currently has three vacant positions out of five available. It is hard to find people to do the work in these pay levels (GS 1 – 3 level). One strategy is to look at having the CHRs be certified medical technicians, and moving the job to a higher pay level -GS5 or 6, which might draw people to the work. Longer term goals include linkages to a community college or trade schools for training. With certified medical technicians, the service site would have 5-6 people who could help expand services. Currently some training is done on site, and national training that is available through IHS. People willing to do the work will be provided the training.

Ft. Thompson is funded for five CHRs, which includes one director, who also provides services. The CHRs have a caseload of 8-10 patients each day depending on the distance they travel and what they are doing for the patients. It is not clear if they bill Medicaid for transportation services delivered to Medicaid enrolled individuals for general care, but they do bill Medicaid when there are specialty referrals for which patients require transportation assistance. Sometimes CHRs support direct patient care in the clinics – they can assist with things like blood pressures. They also go out with the Public Health Nurses (PHNs) or sometimes by themselves to home visits. They do have tools such as the RPMS based system to document, and they keep their own appointment books. IHS is working to incorporate documentation for what they are doing in the EHR so the clinical staff can see the patient information.

Patients call the CHRs to do checks, or the PHNs or other clinical staff might make referrals. The clinical team meets up to 2 times a week for case management "rounds" on all patients who are hospitalized to see when people are expected to be discharged and what should be planned for when they are discharged. This includes motor vehicle operators, CHRs and Tribal ambulance providers. The CHRs sit in on purchased and referred care discussions so they know what is needed for certain patients. They also are involved in the Health Home care coordination discussions for patients who are part of that program.

If all five positions were filled, IHS could meet most of the needs within this area. There are a lot of health promotion and disease prevention programs, too, and the CHRs work with the health educator on those programs, as well as the other things they do. They do a lot of health education activities, especially in coordination with the PHNs. Ft. Thompson is looking at a model of having an Nurse Practitioner who can work with the CHRs. One concern that CHRs raise frequently, is that sometimes they get questions about the medications patients are taking and they are not certain how to answer those questions. It would be helpful for them to have more training on how to be more comfortable answering basic questions and know when they need to hand off to a pharmacist or other clinical for more specialized answers.

Bernie Long will send the formal job description IHS has for CHRs. He also noted there is extensive information about the CHR program on the IHS website (http://www.ihs.gov/chr/)

Brenda Tidball-Zeltinger noted that there are opportunities for billing for some of the CHR services delivered today and Medicaid/IHS can start exploring how to make that happen now (e.g., transportation, wound care). Then this group can continue to work on identifying some of the new services for potential coverage consideration.

The group discussed the opportunity to leverage the health home model and incorporate CHR's for health promotion, care coordination, and referral and support services as examples.

Evie Espinoza, Rosebud Sioux Tribal Health Program – There are a lot of similarities with the Ft. Thompson IHS CHR program, although Rosebud provides CHR services through a 638 Tribal program. A challenge is the population served and how large the geographic service area is. The reservation is 1500 square miles, but the Tribal program covers 20 communities in five counties. The goal is to have one CHR per community, but right now there are only 12 CHRs. About 90 percent of what the CHRs do today is help with transportation. There is only one IHS facility in Rosebud, so a lot of people need to travel quite a distance for care and CHRs are doing a lot of that transportation to the clinic. Currently, the CHR bills only for transportation; they don't have a relationship with a supervising provider for the

CHRs to bill for other services. They have found that the current model within IHS was developed a long time ago and may not be as current as it could be to support the changing needs of the population.

Recently RST created a partnership with Navajo Nation, to learn about their CHR program. Navajo CHRs have a national certification and credentialing program, and the goal is to have the Rosebud CHRs do the same training and certification. Navajo Nation also partnered with their own transportation providers and they created specific transportation providers within the Tribes so the CHRs could focus on more care-related services. They are working through the master contract with IHS to change the scope of work for CHRs so they can provide more direct service.

There is a lot of provider turnover in Rosebud, so having the CHRs do more care services for high-risk patients instead of just doing transportation would help with their care continuity. The goal is to take as much of the care and services to the patient's home as possible. The Navajo CHRs conduct visits in the Navajo language, as well as perhaps incorporating some traditional healing services into what they do for patients. Rosebud would like to be able to provide that level of service to Tribal members. They received funding to establish a partnership with a non-profit in New Mexico called COPE – Community Outreach and Patient Empowerment, and the agreement started November 1. This will provide support and training from organizations such as Harvard Medical School. The CHRs, who have the trusting relationships with the community, now will get help to build the skills and tools they need to change how care can be delivered to Tribal members, and it will help the Tribal health program develop sustainability.

The CHRs' work is primarily patient driven rather than from referrals from IHS. Some providers do help connect people to the CHRs, but there is such high provider turnover and so many contract providers that they don't have good connectivity to the patients or community or with using the CHRs. Rosebud is looking at other ways to bring more services to the patients in their homes – such as mobile clinic – and to have CHRs be more than just the taxi service. The CHR director for Rosebud has also been part of the partnership with the Navajo Nation and is learning a lot from them.

Today there are only 12 CHRs because, similar to IHS in Ft. Thompson, Rosebud has a hard time filling the positions. It takes a special person to do this job, especially in small communities. RST is looking at partnering with the local university and their allied health program to get CHRs their Certified Nurse Assistant training and certification, which would move them toward the national certification that Navajo Nation uses. They also want to explore partnering with the local workforce training program that started a home health technician program.

Rosebud receives a block of funding from IHS to support the CHR program. The current agreement supports what is done today, but probably wouldn't support the new services they want CHRs to be able to do. There is a 638 Master Health Contract that includes Emergency Medical Services, three CHRs, and Alcohol & Drug services (working on accreditation for that program now). Ambulance Services gets some funding from the PRC program. The CHR piece is probably the most appropriately funded for the way the program runs today.

Jerilyn Church noted that a lot of the Tribes have a similar set up with IHS for CHRs as Rosebud. The 638 programs have a much greater ability to be flexible with their programs than the IHS service sites.

Evelyn suggested that more information about what t the CHRs could bill Medicaid for today and how to structure the workers under a provider that so they could take advantage of what is available now would be most helpful. She also will provide a job description of the CHRs at Rosebud for the group.

Sonia Weston, Oglala Sioux Tribe –There are 19 positions, under two 638 contracts (one at Rapid City and one at Pine Ridge). The reservation is very spread out and services are decentralized. The CHRs are set up so there are two in each of nine districts – one who is primarily in the office and one who goes out in the field. Similar to both the Ft. Thompson and Rosebud programs, most of what the CHRs do is provide transportation services. However, they do help a lot in the home and do things like check medications that are out of date, do welfare checks, do home assessments for fall prevention, etc. There is no third party billing for CHR services right now – even for transportation. They have a 638 contract with IHS, so the vehicles they use are part of the fleet.

The Circle of Life organization is a Medicaid provider in their area and they do home health services. But they have limited hours and only one service provider for the elderly (Circle of Life) and Oglala would like to be able have CHRs do some similar kinds of services to help fill those gaps. As with the other sites, it was hard to get people to stay in the CHR jobs.

It is a big challenge at Rosebud and for all the CHR programs, to connect the CHRs and the providers. If a patient is getting served through IHS, as a tribal health provider the CHRs don't necessarily get all the information about those patients. Work is happening to reach out to understand the big health systems better and to let them know how to work with the Tribal CHRs. There is a Tribal resource book they are trying to share so partners have the information. Evelyn will share a copy of this book with the group.

Deb Fischer-Clemens suggested further discussion regarding hospital discharge planning and improved communication with the health systems and IHS on these issues would be beneficial. The CHRs don't know where patients choose to go, so they need to be able to navigate all the systems and help patients regardless of where they go.

It is a big challenge for Tribal members to go to another provider. IHS will send them off and the family has a hard time getting them home and knowing how to help them once they are home. There are even more challenges in literally transporting them all the way home. There should be better coordination among PHNs, CHRs and providers. The providers noted that discharging patients is a huge challenge for them as well. Having information about who can help patients make the transition back to home would be a great resource.

For the next meeting, Jerilyn Church will work on a survey of the Tribal CHR programs and what they to determine what services they are currently providing and to identify what services could be provided if they had more resources. The subcommittee will continue to focus on ways to ensure IHS and Tribal programs are leveraging Medicaid today for transportation and other covered services.

IHS Pharmacy and Medication Management Therapy

Capt. John Schuchardt, IHS Chief Pharmacist presented about IHS Pharmacy services. IHS does a lot of prospective reviews before filling prescriptions. For example, weight-based dosing and other processes to make sure they are prescribing and dosing accurately. They have strict quality controls to ensure they are following good, evidence-based care. They do have a lot of policies and procedures, a lot of education with contract providers. The pharmacists are very engaged in patient care, particularly for

anti-coagulation, diabetes clinics, and medication therapy management (MTM) for complex patients. IHS also does screenings and some diagnostic procedures. For example, they are implementing spirometry in a lot of sites – mostly for smoking cessation. They have an area P&T committee, and each IHS site has their own P&T committee and formulary.

The Great Plains Area is considering taking outside provider prescriptions. Currently they do not accept prescriptions from outside providers (except for referred care – where IHS refers to an outside provider for specific services). IHS wants to collaborate and currently is in talks with Horizon about this opportunity. IHS is proposing to serve as the pharmacy "owner" of the patient, and partnering with other providers to deliver the best care.

There have been issues where the Medicaid formulary doesn't match the IHS formulary, in large part relative to higher cost drugs that exceed the encounter rate paid to IHS for prescription drugs. IHS is open to more than the one model they have now. Any changes just have to be made in a way that would not financially cripple the IHS service sites. Brenda Tidball-Zeltinger noted that IHS should evaluate the financial impact of using the Medicaid payment structure. Given the limitations IHS has to provide drugs that exceed the encounter rate, it may be a financially viable way to cover more expensive drugs.

The definition of MTM was presented from the handout.

IHS would want to leverage this model for high-risk patients. One program started calling patients back 72 hours post discharge at Pine Ridge and Red Lake and it drove down in-house readmissions by 37 percent. Patients with high-cost disease states (COPD, asthma, diabetes, CHF, SMI) and ED patients with certain diagnoses also would be good candidates for MTM.

The group discussed how MTM could be leveraged through the Medicaid Health Home model. Given the target population is common to both MTM and Health Homes they should be leveraging this as part of the health home model. It would be ideal for the pharmacists to see patient records to be able to give most comprehensive assessments. This service also helps assist with medication adherence and the pharmacists in conjunction with care coordinators or CHR's could accomplish this.

It was noted that the Health Homes have been successful in doing this, but it requires the resources – pharmacists – to support it. The group agreed it would be helpful to hear more about Health Homes at next meeting, specifically in context with MTM and the CHR programs.

The group agreed that IHS should move forward with taking outside prescriptions. It would be especially helpful to expand this to the Urban Indian Health programs in Pierre and Sioux Falls, and other areas such as the St. Joseph's Indian School. And IHS would still get the full encounter rate.

The IHS Core Formulary is set nationally. Some Areas have an Area Formulary – Great Plains stopped doing that; but each site has a local P&T committee and recommends changes to the site's formulary. That is another issue that needs to be addressed – the process should be centralized so it is consistent across the State and compatible with Medicaid. The group noted that it would help to look at the data to understand what medications IHS patients are using and how IHS could better match to what Medicaid pays for.

Next Steps/Agenda Items for Nov 18 Meeting:

- Survey of Tribal CHR programs and services (Jerilyn Church)
- Health Homes – how CHRs would support and how MTM could be a component of that service (Health Home providers to give examples)
- Consistency between Medicaid and IHS formularies

Next Meeting:

Wednesday, November 18h, 10 AM – Noon, Central Time, Ramkota Gallery B